
Article:
Mason-Jones, Amanda Jayne orcid.org/0000-0002-4292-3183 and Loggie, Jennifer (2019) Child Sexual Exploitation. : An analysis of Serious Case Reviews in England: Poor communication, incorrect assumptions and adolescent neglect. Journal of public health. ISSN 1741-3842

https://doi.org/10.1093/pubmed/fdy227

Reference: Mason-Jones AJ & Loggie J (2019) Child Sexual Exploitation. An analysis of Serious Case Reviews in England: Poor communication, incorrect assumptions and adolescent neglect. Journal of Public Health. DOI: 10.1093/pubmed/fdy227

Child Sexual Exploitation. An analysis of Serious Case Reviews in England: Poor communication, incorrect assumptions and adolescent neglect.

Dr AJ Mason-Jones[a]

Mrs J Loggie[b]

[a] Associate Professor in Global Public Health, Department of Health Sciences, University of York, University Rd, Heslington, York, England, YO10 5DD

email: amanda.mason-jones@york.ac.uk (corresponding author)

Telephone +44 (0)1904 321321 Fax +44 (0)1904 321383

[b] Health Improvement Manager, Public Health, Health and Adult Services, North Yorkshire County Council, County Hall, Northallerton, England, DL7 8DD

email: jenny.loggie@northyorks.gov.uk

Abstract

Background

Child Sexual Exploitation (CSE) has evolved from being a largely concealed and unrecognised form of child abuse to being the subject of substantial political and public attention. The purpose of this research was to explore health professionals' role in detection and prevention.

Methods

A systematic thematic analysis and synthesis of serious case review (SCR) reports of child sexual exploitation in England using a socioecological theoretical framework was undertaken.

Results

Themes identified included health professionals' lack of understanding of CSE, limited knowledge of the UK law, reluctance to apply relevant policies, and lack of appropriate action. Suboptimal communication with the child, between agencies and with families, lack of understanding of the young person's context, their vulnerabilities and their continued needs for care and protection were also important.

Conclusions

This is the first time, to our knowledge, that an analysis and synthesis of all SCRs related to CSE in England has been conducted. The potential to recognise young people vulnerable to CSE is essential for public health prevention and intervention. Acknowledging that the SCRs represent the worst case scenario, nevertheless, this research highlighted the multi-factorial and complex nature of CSE and identified factors that require system-level awareness, training and intervention.

Background

The World Health Organization (WHO) estimates that globally between 25-50% of all children have been subject to abuse, [1] and that it represents a significant and global problem of 'absolute priority'. The consequences are wide-ranging and impact on health and wellbeing, social and economic functioning, and contribute to excess long term morbidity and mortality. [2] Child sexual exploitation (CSE) is a type of child sexual abuse has long been recognised as a public health issue in the United Kingdom. [3] Guidance has emerged only recently,[4] about what a public health response might look like, and despite the apparent scale of the problem there is very limited data available to estimate the incidence and prevalence of CSE across England. [5]

Serious Case Reviews (SCRs) are a process used in England for collecting information in relation to a child who has died or suffered significant harm where abuse is thought to have been involved. The review process has been developed as it offers an opportunity to learn from cases of significant harm and has the potential to enable agencies to reflect on how they have or have not worked together and what could have been done better.[6]

There are a number of different models of CSE but what distinguishes them is a notable imbalance of power. The contexts and relationships often demonstrate exploitation, where the child or young person is given 'something' she/he needs or wants in exchange for sexual activity. This can occur in person and through the use of technology. [7] Child sexual exploitation can present differently in different sitations, [8-12] which can make it difficult for public health professionals (PHPs) to detect. Exploitative relationships are characterised, in the main, 'by the child's limited availability of choice', which may result from their social and economic environment and/or emotional vulnerability. [13] Evidence suggests that drug or alcohol misuse, self-harm, going missing, living on the streets, belonging to a gang, having intellectual disabilities or coming from a fragmented family background can contribute to being at risk of CSE. [14] However, any child or young person can be at risk of CSE, regardless of family background. Boys and young men as well as girls and young women are at risk. Understanding the pattern and warning signs for CSE can support recognition and appropriate responses. [15]

The complex nature of this kind of abuse, means that many victims do not come forward to report exploitation or do not recognise they are a victim of CSE. [10] Typically, the perpetrator will be well-liked and plausible and be in a position of power, and will use this power to control and manipulate the young person. [16] Most victims of CSE are encouraged to be secretive about their meetings and activity with perpetrators during 'grooming' which ensures it remains hidden.

Sexual Exploitation has a long term negative impact on health. Children and young people suffer significant physical and mental health issues. Some young people receive the support required to promote recovery, whilst others continue to suffer life-long impairment which can occasionally lead to their death, through suicide or murder. [13] This highlights the importance of early recognition, swift referral and action. Given the long term consequences for physical and mental health, this presents a major public health concern which necessitates a more systematic approach to prevention and intervention by health professionals.[5]

Health professionals such as general practitioners (GPs) and nurses, working in schools and clinics, who are unaware or unsure of signs and symptoms of CSE may not report or accurately record it. Furthermore, differing approaches to recording and defining CSE may further exacerbate the problem of identification and protection of young people.

The aim of this review was to undertake a thematic analysis of SCRs of CSE to identify commonalities in health professionals' practice across reviews, to synthesise the evidence and to make recommendations to improve policy and practice.

Methods

The National Society for the Prevention of Cruelty to Children (NSPCC) database, the 'National Case Review Repository',[17] collects together published SCR reports covering all aspects of child abuse and neglect. This database is held in collaboration with the Association of Independent Local Safeguarding Children Boards and is the only available database in the public domain. In order to be included in this review the SCR had to include child sexual exploitation as a feature, published between 1st January 2013 – 30th September 2017, have no redacted information and be conducted within England. The choice of date was related to the change in legislation in 2013, whilst choice of country was related to different approaches and statutory guidance in reporting; Wales has child practice reviews, Northern Ireland has case management reviews and in Scotland significant case reviews.

A search of the database was conducted in September 2017 using the following terms: 'child sexual exploitation' OR 'child* adj5' 'sex* ADJ exploit*' OR 'child* adj9' 'sex*adj3 exploit* OR 'child abuse, sexual' or '*sex offences' OR '*child abuse' OR Sex*adj4 (exploit* OR work* OR groom* OR molest*) OR 'sell* adj sex*' OR (sex* adj3 trad*) OR pimp* OR Prostitut* OR pornograph*. However as the title and abstract did not provide enough detail to assess whether the SCR was relevant all available reports available were retrieved for assessment. Where reports centred around other forms of child harm not related to CSE they were excluded.

The search yeilded 197 Serious Case Reviews. The online version of each SCR was reviewed to explore whether it fitted the inclusion criteria. This resulted in 168 SCRs being excluded as they were not relevant. The full text of twenty nine SCRs were reviewed in detail. Eighteen did not meet the inclusion criteria at this stage. Finally eleven SCRs met the inclusion criteria (Figure 1). A rigourous process of thematic analysis was undertaken using the approach suggested by Braun and Clarke,[18] informed by a socioecological theoretical framework.[19] The review reports were read and compared. Key themes and patterns that emerged were identified, explored, documented and coded. To further understand the meanings and context of the SCR the themes were coded at the various levels of the socioecological framework (systems and structures, community, institutions and organisations, interpersonal and individual). An iterative approach was used and themes were synthesised across reviews to enable reflection on potential systemic shortfalls in practice that could be addressed.

Results

Eleven SCRs were included (Table 1) which included 23 young people of whom 22 were female, 1 was male, with ages ranging from aged 14 to 17. Six reviews focussed on one child and the remaining five were focussed on more than one. Perpetrators were male in all but one case where a female was also involved. The levels at which specific problems emerged were mapped to the socioecological model used in the WHO's 'Health of the World's adolescents' report, [20] where factors which undermine or have impact on health can be at a range of levels including individual, interpersonal, organizational and community but can also be at the structural and macro levels (systems and structures). The themes that emerged were related to knowledge of legislation and policy, understanding the child's environment, their vulnerabilities and communication with their families, interagency communication and safeguarding, communication with and listening to the child, and lack of understanding, perception and judgement of risk. In summary there was an underlying trend of lack of awareness of CSE. (Figure 2).

Knowledge, understanding and risk

Across all SCRs, the lack of knowledge and awareness of CSE was evident. Most of the professionals did not understand the indicators of CSE and thus did not explore the issues that young people were presenting with. This lack of knowledge meant that the patterns of abuse were not being recognised and the behaviours being exhibited by the child were the focus of attention, rather than looking for the cause of those behaviours, or seeing them in the context of other factors. Similarly, it was not

thought that the behaviour was a reaction to 'something' such as abusive relationships or deeper contextual issues.

It was also clear that health care professionals were often confused by the term 'risky behaviours' and tended to consider them to be an individual problem of the child rather than seen as a risk factor and sign of CSE. However, it was not only health professionals that stuggled with this. In the SCRs the term 'risky behaviours' was been used by all professionals interchangeably. There were common signs across all the reviews. These included changes in behaviour which escalated into being increasingly difficult and challenging, missing school, going missing from home, attendance for sexual health advice due to early pregnancy or acquiring sexual transmitted infections (STIs), and episodes of self-harm. For example, one of the young women made 'numerous allegations and sought sexual health advice'. On each occasion the health professionals involved focused on giving advice rather than exploring the reason for the repeated attendance and did not consider or discuss consent or explore the possibility of abuse. Often children were not aware of the risks they were exposed to. In three of the SCRs, it was documented that the children did not see themselves as victims and the professionals involved did not question this or raise concerns, which allowed the abuse to continue.

Communication and listening

One of the strongest themes which emerged across all SCRs was the importance of listening to the child and their family; but listening beyond the face value. This theme presented differently across the SCRs where young people either made clear disclosures or remained quiet and presented only non-verbal or physical evidence of the abuse. Parents were either vocal in asking for help to deal with their child who was presenting as 'out of control' or were disengaged and in denial of what was happening. In some cases health care professionals, particularly in primary care, had strong and long standing relationships with the child and their family which influenced how they were perceived. For example, one case review described a quiet child who, when questioned, denied any sexual activity if her mother was present. She then managed to conceal her pregnancy until 33 weeks' gestation. Health care professionals consistently missed her non-verbal cues and the physical indications. This young woman had a very vocal parent who continually spoke for her and attended every appointment with her. The parent requested a prescription for the contraceptive pill for the young woman and informed the health professional that it was to help regulate her mentrual periods and not because she was sexually active. This explanation was taken at face value, despite the fact that

she was already subject to a child protection plan because of concerns about the risk of grooming and sexual abuse by the male residing in her home. The link between the child protection plan and need for contraception was not made. This reflected findings in the other SCRs when issues around contraception use were raised. It was often reported that health care professionals tended to address the parent or whoever accompanied the young person instead of the child herself.

In at least three of the SCRs reported the young women were clearly vocal about sexual abuse, but these concerns were not heard by the health professionals involved. For example one young woman 'disclosed rape at 12, 13 and 14 years of age' however it was recorded in the notes as her 'making allegations of rape' and that she had consented to sexual activity despite the fact that consent is legally not possible under 13 years of age. In another review a mother disclosed that her daughter had 15 – 20 sexual partners but the issue of consent was never raised by the health professionals involved and so allowed the sexual exploitation to remain hidden.

Context and vulnerability

Lack of understanding the contexual factors affecting the child and their family was a theme that was strongly represented throughout. Many of the children were in local authority care, had accounts of being missing from home or came from families that had complex problems. These factors tended to engender a perception that the child was, by choice, placing themselves in situations of risk and subsequently did not lead to investigations to find out why. Sometimes parents prevented access to services. For example in five of the SCRs parents were the blockage to receiving better quality care for the child. There were suggestions in the records that often detailed these contextual vulnerabilities but this was commonly not communicated or shared between agencies involved. This meant that the neglect of the young people involved was not picked up. Even when parents asked for help the response they got was to suggest that the behaviour of the young person was their responsibility and they were left without support. In most of the reviews included, agencies were not focussed on the vulnerabilities of the child and their family.

Discussion

Main findings from this study

We found that common themes emerged at all levels of the social ecology. The SCRs highlighted health professionals' poor understanding of CSE and their role in safeguarding against it. This was principally around the perception of the risk factors for CSE, understanding about consent to sexual activity and judging the young person's vulnerability. Communication and listening beyond the face value were also highlighted in interactions with young people themselves, their families and

between agencies. The importance of looking at family and contextual factors that may indicate vulnerability of the young person was highlighted. This included supporting parents when they are asking for help with their child's challenging behaviours whilst simultaneously understanding that disengagement from services and parents blocking access to health services may be also be a key indicator that something is awry.

Ultimately the precursor to CSE often appeared to be neglect, the recognition and response to which, was suboptimal. The young person often became 'invisible' to the health professional and parents' needs were prioritised. Links were therefore not made between this and CSE. Despite national and local guidance on the neglect of children, there is a lack of guidance around adolescent neglect despite being specified in legislation [21] (add children act). Therefore raising awareness of risk factors and indicators of CSE appears is crucial for successful early intervention.

What is already known on this topic

There is support for the use of a public health model in safeguarding against child abuse. [22-24] This approach provides an approach that can assist health workers to prevent, recognise and respond to CSE. Despite the growing awareness of CSE, health professionals consistently struggle with the identification and recognition of CSE. [5, 25] A series of major public inquiries have previously uncovered the failure to recognised the signs and act appropriately, across the health and social care system. [26, 27] Health professionals provide services that seeks to improve the health outcomes for young people, and particularly those deemed 'at risk'. However, limited 'intelligence gathering' and data sharing leads to difficulties between organisations who are often guided by different protocols. In addition, as CSE is not a diagnosis it cannot be recorded easily on systems making it more difficult to detect in healthcare settings. [5]

What this study adds

This is the first attempt, to our knowledge, to synthesise evidence from SCRs on child sexual exploitation. SCRs have been previously been neglected in public health research but have the potential for developing new insights and recommendations for policy and practice. Learning from SCRs on an individual basis is a common part of the work of Safeguarding Boards however research considering a collective body of SCRs is less common and rarer from a public health perspective.[28] The purpose of this review was to identify the gaps in public health professional's knowledge, training and skills in recognising and intervening in cases of CSE. In particular it suggests that adolescent neglect may be a previously unidentified precursor to child sexual exploitation.

Limitations of this study

Limitations of this study is that the use of SCRs reflect the 'worst case scenario' and highlighted poor practice only. Many young people who experience CSE will never become the subject of an SCR and many health care professionals will be actively picking up CSE in their practice. We also only included SCRs that occurred in England, so the findings may not reflect common themes that might emerge in other countries. Finally this study is the best option currently available at present as we have no other data that can determine patterns of CSE.

The focus of this study was health professionals but they cannot meet the complex needs of children and young people alone. Therefore working together with other agencies to ensure that young people gains access to the support and services they need is crucial. A systematic pubilc health approach is ideal to look for patterns and share this knowledge with other professionals and with families so they too feel that they can engage and begin to address this difficult and complex problem.

Conclusion

Professionals are often unclear about statutory guidance and protocols and the risk to the child is increased when they become 'invisible', neither seen nor heard by parents or health professionals. Therefore learning from serious case reviews can highlight systemic patterns of failure and has the potential to highlight good practice in protecting children. However, presentation and reporting of serious case reviews should be standardised to help us with this learning.

Acknowledgements

Thanks to the local authorities who have made their serious case reviews available and to the NSPCC for enabling access to them. Thanks also to the University of York who funded Dr Mason-Jones' participation and North Yorkshire County Council who funded Jenny Loggie.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

1. World Health Organization. Violence and Injury Prevention; Child maltreatment (Child Abuse). http://www.who.int/violence_injury_prevention/violence/child/en/ [Accessed 18th October 2018]2018.
2. Segal L, Dalziel K. Investing to Protect Our Children: Using Economics to Derive an Evidence-based Strategy. Child Abuse Review. 2011; 20:274-89.
3. Chase E, Statham J. Commercial and sexual exploitation of children and young people in the UK—A review. Child Abuse Review. 2005; 14:4-25.
4. Public Health England. Child sexual exploitation: How public health can support prevention and intervention: Public Health England2017 Contract No.: PHE publications gateway number: 2017192.
5. Academy of Medical Royal Colleges. Child Sexual Exploitation: Improving recognition and response in health settings. London: Academy of Medical Royal Colleges. 2014.
6. Department for Education. Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children: The Stationery Office; 2006.
7. Department for Education. Child Sexual Exploitation. Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation. London: Department for Education2017 Contract No.: Reference: DFE-00056-2017.
8. Beckett H. Not a world away: the sexual exploitation of children and young people in Northern Ireland. Barnado's Northern Ireland: Belfast. 2011.
9. Jago S, Arocha L, Brodie I, Melrose M, Pearce JJ, Warrington C. What's going on to safeguard children and young people from sexual exploitation? how local partnerships respond to child sexual exploitation: University of Bedfordshire2011.
10. Smeaton E. Running from hate to what you think is love: The relationship between running away and child sexual exploitation. Barnado's, Ilford. 2013.
11. Pitts J, Shuker L, Warrington C. Research into gang-associated sexual exploitation and sexual violence. 2012.
12. Berelowitz S, Firmin C, Edwards G, Gulyurtlu S. I thought I was the only one. The only one in the world. The Office of the Children's Commissioner's inquiry in to child sexual exploitation in gangs and groups: interim report (PDF) London: Office of the Children's Commissioner. 2012.
13. Department for Children Schools and Families. Safeguarding Children and Young People from Sexual Exploitation. London: HMSO2009.
14. Ashby J, Rogstad K, Forsyth S, Wilkinson D. Spotting the Signs: a national toolkit to help identify young people at risk of child sexual exploitation. Sexually transmitted infections. 2015; 91:231.
15. Merton County Council. Children and Young People and Maternal Health in Merton; Child Sexual Exploitation. Merton.2015.
16. Barnardo's. Puppet on a String: The Urgent Need to Cut Children Free from Sexual Exploitation. Ilford.: Barnardo's2011.
17. NSPCC. The National Case Review Repository https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/2017 [23rd October 2017].
18. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology. 2006; 3:77-101.
19. Fong R, Cardoso JB. Child human trafficking victims: Challenges for the child welfare system. Evaluation and program planning. 2010; 33:311-6.
20. World Health Organization. Health for the world's adolescents: a second chance in the second decade: summary. Geneva: World Health Organization2014 Contract No.: WHO/FWC/MCA/14.05.

21. United Nations General Assembly. Convention on the Rights of the Child,. 1989.
22. Putnam-Hornstein E, Webster D, Needell B, Magruder J. A public health approach to child maltreatment surveillance: Evidence from a data linkage project in the United States. Child Abuse Review. 2011; 20:256-73.
23. Barlow J, Calam R. A public health approach to safeguarding in the 21st century. Child Abuse Review. 2011; 20:238-55.
24. Brown J, O'Donnell T, Erooga M. Sexual abuse: a public health challenge. London: NSPCC; 2011.
25. Kirtley P. If you Shine a Light you will probably find it. Report of a Grass Roots Survey of Health Professionals with Regard to their Experiences in Dealing with Child Sexual Exploitation. 2013.
26. Ansbro M. The Independent Inquiry into Child Sexual Exploitation in Rotherham, 1997–2013. Probation Journal. 2014; 61:429-32.
27. Coffey A. Real voices: child sexual exploitation in Greater Manchester. an independent report by Ann Coffey (MP), available at: http://anncoffeymp/ com/wp-content/uploads/2014/10/Real-Voices-Final pdf (accessed 7 February 2015). 2014.
28. Brandon M, Sidebotham P, Bailey S, Belderson P. A study of recommendations arising from serious case reviews 2009-2010. 2011.